MEDICARE ADVANTAGE PLANS

(MANAGED CARE PLANS)

SECTION H

MEDICARE ADVANTAGE PLANS

Introduction

Medicare Advantage Plans (MA) are health plan options that are approved by Medicare and run by private companies. These plans are also known as Medicare Part C, Medicare+Choice, and Medicare Managed Care Plans. They are another way of getting your Medicare benefits. There are five types of plans available; however, not every type of plan is available throughout the state. These types are:

- Medicare Health Maintenance Organization (HMO)
- Medicare Preferred Provider Organization (PPO)
- Medicare Private-Fee-for-Service (PFFS)
- Medicare Special Needs Plans (SNP)
- Medicare Medical Savings Account Plans (MSA)

Medicare HMO's have been an option for Medicare beneficiaries since the 1970's. The Balanced Budget Act of 1997 authorized new plans such as PPO, PFFS and MSA plans. Regional PPO plans and SNP were created with the Medicare Modernization Act of 2003. Of the almost 43 million Medicare beneficiaries 19% (8.3 million) receive their Medicare benefits through MA plans.

How do these plans work?

If you join one of these plans, you will generally receive all your Medicare covered health care through that plan. MA plans provide your Part A and Part B coverage and must cover medically-necessary services. They may offer additional benefits such as prescription drug, vision and dental coverage. Medicare pays a set amount of money for your care every month, whether or not you use the covered services. These plans often have networks, which means that you may have to see doctors who belong to the plan or go to certain hospitals to get covered services.

MA plan benefits and out-of-pocket costs may differ from Original Medicare. Since each plan can vary, it is important that you review plan materials carefully for details about copayments and covered services.

Who Can Join?

MA plans are available to most people with Medicare. To be eligible to join a MA plan you must:

- Live in the plan's service area.
- Be enrolled in Medicare Part A and Part B (if you are already in a MA plan and only have Part B, you may stay in the plan).
- Not have End-Stage Renal Disease (ESRD - permanent kidney failure requiring dialysis or a kidney transplant). There are a few exceptions:
    - If you are already in an MA plan when diagnosed, you may either stay in your current plan, or join another plan offered by the same company
    - If you have ESRD and are in an MA plan that leaves Medicare or no longer provides coverage in your area, you have a one time right to join another MA plan. You do not have to use your one time immediately, you can choose to join at a later date in the plan is still accepting new members.
    - You may join a Special Needs Plan (SNP) for people with ESRD in one is available in your area. (Currently there are no SNP plans for ESRD in Indiana)

In addition, you must:

- Agree to provide necessary information to the plan,
- Agree to follow the plan's rules, and
- Belong to only one MA plan at a time.

When Can I Join?

There are different times when you can join or switch a MA plan. These time periods are as follows:

- Initial Coverage Election Period
- Annual Election Period (AEP)
- MA Open Enrollment Period (OEP)
- Special Enrollment Periods (SEP)

Initial Coverage Election Period
During your Initial Coverage Election Period when you first become eligible for Medicare you will have a 7 month enrollment period.

- If you are eligible for Medicare **due to age** (turning age 65), your initial enrollment will begin 3 months before the month you turn age 65 and will end 3 months after the month you turn age 65.
- If you are eligible for Medicare **due to disability**, your initial enrollment will begin 3 months before to 3 months after your 25th month of Social Security Disability eligibility.

Annual Election Period (AEP)
Each year from November 15 to December 31, you can make changes in your plan enrollment. You may choose to join an MA plan with or without drug coverage or return to Original Medicare with or without a Medicare prescription drug plan. Changes will be effective the following January 1. Unless the plan has a capacity limit waiver, MA plans must accept eligible new members during the AEP. A capacity limit waiver means the plan has been authorized to close enrollment because it already has reached a certain number of enrollees.

MA Open Enrollment Period (OEP)
In addition to the Annual Election Period, you have an opportunity to change during the OEP. The OEP is January 1 through March 31 each year. During this time you will be able to switch to a different type of MA plan, but you cannot change your drug coverage (nor can you enroll or disenroll in a Medicare Medical Savings Account, if offered in your area). The chart below shows your options during the OEP.

If you have . . .	**You can join . . .**	**You CANNOT join . . .**
MA plan with prescription drug coverage (MAPD)	Another MAPD or switch to Original Medicare & PDP or an PFFS & an PDP	An MA-only or switch to Original Medicare only
MA plan with no drug coverage (MA-only)	Another MA-only or switch to Original Medicare only	An MAPD or switch to Original Medicare & PDP
Original Medicare & a Medicare Prescription Drug plan (PDP)	An MAPD or an PFFS and the same PDP	An MA-only or switch to another PDP
Original Medicare	An MA-only	An MAPD or join a PDP

Special Enrollment Periods (SEP)
You can switch to another MA plan under special circumstances. These include the following:

- If you move out of your plan's service area
- If your plan decides to leave the Medicare program
- If your plan reduces its service area and your area is no longer covered by the plan
- Special trial rights available if you have joined a MA plan for the first time, you may switch back to Original Medicare anytime within the first 12 months of your plan coverage.
- Two SEP for new MA enrollees:
    - If the beneficiary enrolled in an MA plan when they were first aged-in to Medicare (age 65), they can disenroll anytime during the first 12 months after their coverage started. They would then have the right to purchase any Medigap plan A through L.
    - If the beneficiary dropped a Medigap plan to enroll in an MA plan for the first time, they can disenroll anytime during the first 12 months and return to their original Medigap (if still available) or choose A, B, C, or F.

Types of MA Plans

Medicare HMO's

In a Medicare HMO, the co-payments and coinsurance you pay is set by the plan. There are doctors and hospitals that contract with the plan (join the plan's network). **Generally you must get your care and services from the plan's network.** If you get your health care outside of the network, you may have to pay for these services yourself. In most cases, neither the plan or Original Medicare will pay for these services.

When you join a Medicare HMO plan, **you may be asked to choose a primary care doctor**. Your primary care doctor is the doctor you will see first for most health problems. In many HMO's you must see your primary care doctor before you can see any other health care provider. **You will usually need to get a referral from your primary care doctor to see a specialist** (i.e. cardiologist). If the type of specialist you need is not available in the plan's network, the plan will arrange for care outside the network.

If you are considering joining a Medicare HMO and want to keep seeing your current doctor, you should call and ask your doctor (usually the doctor's billing department) to see if he is in the network. Contact the plan for information on providers and facilities in their network. Keep in mind doctors can join or leave a network. If your primary care doctor leaves the HMO plan, the plan will notify you in advance and provide an opportunity to pick a new doctor.

There are **special rules for certain services**. Women can go once a year without referral for a screening mammogram. They can go every other year to a specialist in the network for Medicare covered routine and preventive women's care services.

If a Medicare HMO includes prescription drug coverage, you will pay a co-payment or coinsurance for each covered prescription. In most, cases if you are in a MA plan, you may not join a separate Medicare prescription drug plan to get drug coverage.

Medicare PPO's

Medicare PPO's use many of the same rules as Medicare HMO's. However, in a PPO generally you can see any doctor or provider that accepts Medicare. You do not need a referral to see a specialist. If you go to doctors, hospitals or other providers that are not in the network (out of network, or non-preferred), you do not need a referral, but you will usually pay more. Every PPO plan must pay for all covered services received out-of-network, but every plan is different in what your cost share (co-payment/coinsurance) will be. PPO plans can be either local (cover individual counties) or regional (regions can cover an entire state or multiple states). Beginning in 2006, regional PPO's were available in most areas of the country.

In a regional PPO you will have an added protection for Medicare Parts A and B benefits because regional PPO's limit out-of-pocket costs. The annual out-of-pocket limit varies by plan. Regional PPO's may have a higher yearly deductible and/or premium than other PPO's.

As a PPO member you may also be able to get your Medicare prescription drug coverage from the PPO plan.

Medicare PFFS Plans

In a PFFS plan, you can choose which provider you will see. You do not need a referral to see a specialist, and can get service outside of your service area. While you can go to any Medicare approved doctor or hospital, that provider must accept the terms and conditions of your plan's payment schedule.

You may get extra benefits not covered under Medicare, such as extra days in the hospital. The plan, rather than Medicare, decides what you pay for the services you receive. You can get your Medicare prescription drug coverage from a PFFS if offered, or you can join a stand-alone Medicare prescription drug plan if drug coverage is not offered by your PFFS.

Medicare Special Needs Plans (SNP)

Special Needs Plans are MA plans specially designed for people with certain chronic diseases and other specialized health needs. There are three types of SNP:

- Plans designed to meet the needs of people **who live in certain institutions** (like a nursing home).
- Plans designed to meet the needs of **specific chronic or disabling conditions** (like ESRD, Diabetes, Cancer).
- Plans designed to meet the needs of people who are eligible for both **Medicare and Medicaid** (dual-eligibles).

SNP's are designed to provide focused care management, special expertise of the plan's providers, and benefits tailored to enrollee conditions.

For Example:

An SNP for people with diabetes might have:

- additional providers with experience caring for people with diabetes,
- have focused special education or counseling
- and have nutrition and exercise programs designed to help control the condition

An SNP for people with both Medicare and Medicaid might help members:

- access community resources
- coordinate many of their Medicare and Medicaid services

SNP must include Medicare prescription drug coverage.

SNP in Indiana

Currently in Indiana there is only one company offering Special Needs Plan. These plans are available as follows:

- **SNP Low Income:** Adams, Allen, Boone, Fulton, Hamilton, Hancock, Hendricks, Johnson, Kosciusko, Madison, Marion, St. Joseph, Wells
- **SNP Chronic Disease:** Adams, Allen, Fulton, Kosciusko, St. Joseph, Wells
- **SNP Institutional:** Boone, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion

Medicare MSA Plans

Medicare Medical Savings Account Plans became available in 2007. These plans are similar to Health Savings Accounts available outside of Medicare, and they have two parts.

The first part is **an MA plan with a high deductible**. The plan will begin to cover your costs once you meet a high yearly deductible, which varies by plan. During the time you are paying for services before the deductible is met, providers cannot charge you more than the Medicare approved amount for services received. This part is also referred to as your Health Plan.

The second part is a special type of **savings account**. The Medicare deposits money into your account. You can choose to use money from this account to pay your health costs, even before you meet the deductible. Money left in your account at the end of the year stays in the account.

For more information contact 1-800-Medicare to ask for a copy of *Your Guide to Medicare Medical Savings Account Plans*, or visit http://www.medicare.gov/Publications/Pubs/pdf/11206.pdf.

Medicare Savings Plans Fact Sheet—by Health Assistance Partnership

Medical Savings Accounts are the result of the Balanced Budget Act (BBA) of 1997 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. MSAs are known as "Medicare Savings Accounts." They can exist through employers, state benefits, and through the federal government. This information refers only to the federally qualified Medicare Savings Accounts (MSAs) that are offered under the Centers for Medicare & Medicaid Services as approved Medicare Advantage plans for 2007. The Medicare Advantage **MSA plan enrollments for 2007 coincide with the Part D Annual Enrollment Period, but they are not synonymous and differ greatly in structure and benefit. Applications are in paper form through the plan, one cannot enroll on-line.**

Theoretically, MSAs had the potential to exist since 1997; it was not until very recently that any plans were offered. For 2007 they are offered in both demonstration projects that are statewide, and "regular" plans that are locally offered. In general, one who signs up for an MSA is insuring themselves for catastrophic coverage. They are designed for someone who can afford to spend at least $2,500 per year out of their own pocket for routine or preventive care, in addition to and apart from, any Part D related expenses. **In general, MSAs allow you to choose a Medicare Advantage Health Plan that is linked to a newly developed personal savings account used to pay for medical expenses.** By using this account to pay for medical expenses you are meeting your health plan's high deductible. First you choose a health plan and then they supply you with any and all banking information. You cannot choose your own bank or use an existing account. Banking arrangements are set up by the plan.

The following chart illustrates the most important aspects of MSAs:


BANK


DEDUCTIBLE/Premiums


HEALTH INSURANCE


Prescription Drugs

Medicare Advantage Health Plan	Medicare Advantage Health Plan	Medicare Advantage Health Plan	Stand-Alone PDP - Part D Prescription Drug Coverage
Medicare deposits a lump sum anywhere from $1,000 up to $2,000 at the beginning of the year into an interest bearing savings account.	High deductible must be met before benefits of Medicare Advantage Plan takes effect.	Local (Regular) or statewide (Demonstration) plan.	MSA Medicare Advantage Plans do not carry drug coverage.
Lump sum is used to meet medical expenses that go towards your deductible.	Still paying Part B premium in addition to any deductibles, premiums or copays under the MA MSA plan	Access to any Medicare provider within the geographic area ("network") set forth by the plan	Have option to sign up for a stand alone Medicare Part D benefit.
Deductible is met through medical spending and cannot be more than $9,500 per year.	Medicare pays premium on behalf of beneficiary directly to the MA plan.	Benefits are similar to Original Medicare.	No coordination of coverage occurs between the MSA MA plan and a PDP Part D plan.
You can use an electronic debit card to pay for your medical expenses linked to this account.	Can charge a separate premium for additional coverage such as dental, vision, hearing, etc. up to yearly cap.	Non-Medicare participating providers can "balance bill" up to 15%.	You can use the funds in your MSA account to cover Part D costs and they do count towards TrOOP, however, using the funds in this way is not tax exempt.
You cannot deposit funds in to this account.	Out of pocket expenses capped yearly at $9,500 - including yearly deductible.	Those with Medicaid, supplemental "Medigap," retiree, union, VA, TFL or FEHBP or other health insurance cannot enroll in an MSA plan	
Money that goes unused after a year of being in the plan rolls over into next year.	Demonstration MSA plans allow for copayments or coinsurances after meeting the deductible up to yearly cap. Regular plans cover 100% of any Medicare covered cost once deductible has been met.	Plans cannot offer supplemental benefits to cover the cost of the deductible. Access to your health plan's coverage under Medicare only occurs after you have met your yearly deductible.	When utilizing a Special Enrollment Period to disenroll or change your MSA MA at any time, you can keep your stand -alone Part D PDP benefit.
Income tax is paid on any money used towards non-medical expenses.			

Medicare Cost Plans

Medicare Cost Plans are available in limited areas of the country. These plans have many of the same rules as Medicare HMO plans; however:

- If you go to a non-network provider, the services are covered under Original Medicare.
- You can join a Medicare Cost Plan any time it is accepting new members, and can leave anytime to return to Original Medicare.
- You can get Medicare prescription drug coverage from your plan if it is offered, or you can buy a separate Medicare drug plan to add prescription coverage.

These are general rules for Medicare Cost Plans. Rules may differ for some plans, be sure to read plan materials carefully.

Comparing Plans

Since each plan can vary, it is important that you read the plan materials carefully. There are several questions you can use when consider enrolling into a Medicare Advantage Plan. These questions include:

- Are prescription drugs covered?
- Do I need to chose a primary care doctor?
- Is my current doctor or preferred hospital part of the network?
- Am I willing to switch doctors?
- Can I get my health care from any doctor or hospital?
- Do I have to see a primary care doctor to get a referral to see a specialist?
- What else do I need to know about this type of plan?

See pages H-11 and H-12 for a Medicare Advantage Plan Compare.

Medicare Advantage Plan Compare

Plan Name:_____

Is this a local or regional plan? _____
Is Medicare approved prescription drug coverage available?_____
If prescription coverage is available, is there an additional premium? _____
Are my current doctors members of the network? _____
Is the hospital I normally go to in the network? _____

Benefit	*What I pay with Original Medicare*	*What I pay in network*	*What I pay out of network*
Plan Premium	$0.00	_____	_____
Part A			
Hospital Inpatient			
1-60 days	$1,100	_____	_____
61-90 days	$275 per day	_____	_____
91-150 days	$550 per day	_____	_____
> 150 days	Full amount	_____	_____
Skilled Nursing			
1-20 days	$0.00	_____	_____
21-100 days	$137.50 per day	_____	_____
> 100 days	Full amount	_____	_____
Home Health	$0.00	_____	_____
Hospice - Durable Medical Equipment	20% approved amt	_____	_____
Blood			
First 3 pints	Full Amount	_____	_____
Additional pints	20%	_____	_____
Part B			
Premium	$110.50*	$110.50*	$110.50*
Medical and other Services			
Deductible	$155	_____	_____
Coinsurance	20% approved amt	_____	_____

* if your annual income is greater than $80,000 ($160,000 - married) your premium may be higher

Benefit	*What I pay with Original Medicare*	*What I pay in network*	*What I pay out of network*
Part B con't			
Outpatient Therapies	20% approved amt	_____	_____
Outpatient Mental Health	50% approved amt	_____	_____
Outpatient Hospital	Coinsurance based on type of service	_____	_____
Preventative Services			
Bone Mass Measurement	20% approved amt	_____	_____
Colorectal Cancer Screening	20% approved amt	_____	_____
Diabetes Services and Supplies	20% approved amt	_____	_____
Glaucoma Screening	20% approved amt	_____	_____
Mammogram	20% approved amt	_____	_____
Pap test, Pelvic & Breast exams	$0.00 pap test 20% pap collection and exams	_____	_____
Prostrate Cancer Screening	$0.00 PSA 20% for digit rectal Exam	_____	_____
Flu & Pneumococcal Vaccines	$0.00	_____	_____
Welcome to Medicare Physical	20% approved amt	_____	_____
Additional Benefits Not covered by Medicare			
_____		_____	_____
_____		_____	_____
_____		_____	_____
_____		_____	_____

Your Rights in an MA Plan

All people with Medicare have certain guaranteed rights and protections. You have them whether you are in Original Medicare, a MA plan or have a Medigap policy. Your rights include:

- The right to get the health care services you need.
- The right to receive easy-to-understand information.
- The right to have your personal medical information kept private.

When you enroll in a MA plan, you are guaranteed additional rights.

- If you have a complex or serious medical condition, you have the right to get a treatment plan that lets you see a specialist within the plan as many times as you and your doctor think you need.

- Women have the right to go directly to a women's health care specialist within the plan for routine and preventive health care services.

- When you ask your plan how it pays its doctors, the plan must tell you. Medicare does not allow MA plans to pay doctors in a way that would not let you get the care your need.

- You have the right to file a complaint or appeal, and to a fair, efficient and timely process to resolve differences with your health plan. This includes the initial decision made by your plan, an internal review, and an independent external review.

- You have the right to a fast appeals process whenever you are getting services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility.

Appeal in Medicare Advantage Plans

If your plan will not pay for, does not allow, or stops or reduces a course of treatment that you think should be covered or provided, you have the right to appeal. If you think your health could be seriously harmed by waiting for a decision, you can ask the plan for an expedited appeal decision.

Your plan must provide, to you in writing, information on the process of filing an appeal. The plan must also provide notices after every adverse coverage determination (plan's initial decision) or appeal. In addition, all appeal entities are required to send written notice when they make adverse decisions. These notices will explain:

- the decision, including detailed explanation of why services were denied,
- information on the next appeal level, and
- specific instructions about how to file the appeal.

Appeal Levels

Following an adverse decision by the plan, you have the following levels of appeals:

- **Plan Reconsideration** - This must be filed within 60 days of the date of the determination notice; no minimum amount in controversy needed; health plan has jurisdiction.
- **Independent Review Entity (IRE)** - This is automatic if the Plan Reconsideration does not change the initial determination; no minimum amount in controversy needed; IRE has jurisdiction.
- **Administrative Law Judge (ALJ) Hearing** - This appeal must be filed within 60 days of the date of IRE decision; minimum amount $120 (adjusted annually).
- **Medicare Appeals Council (MAC) Review** - This appeal must be filed within 60 days of receipt of ALJ hearing decision/dismissal; there is no minimum amount to appeal a case to the MAC; Jurisdiction Department of Health and Human Services Departmental Appeals Board (DAB).
- **Judicial Review** - This is the final step of appeal. The appeal must be filed within 60 days of receipt of DAB decision/ declination; minimum amount $1,180 (adjusted Annually); jurisdiction U.S. District Court.

Fast-Track Appeals
This process is available when you believe your services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility are ending too soon. Your provider must give you a *Notice of Medicare Non-coverage* (NOMNC) at least 2 days before your services are expected to end. These fast-track appeals are not automatic, but if your do appeal, the plan must provide a *Detailed Explanation of Non-coverage*. You will get a decision within 2 days from the Quality Improvement Organization (QIO) that will decide if services need to continue.

Inpatient Hospital Appeals
The provider or plan must provide a *Notice of Discharge and Medicare Appeal Rights* (NODMAR) at least the day before services end if:

- you disagree with the discharge decision, or
- your provider/plan is lowering the level of your care within the same facility.

You can appeal by sending a request to the QIO by noon of the day after receiving the NODMAR. The decision from the QIO is usually received within 2 days. You will remain in the hospital pending the QIO's decision, and generally will incur no financial liability during the appeal, even if the decision is not in your favor.

MA Plan Marketing Guidelines

MA plans may send information to or call Medicare beneficiaries about Medicare prescription drug coverage they are offering. They may use the Medicare Rx seal on marketing material if they offer a MAPD.

Plans must:

- Use marketing materials that have been submitted to CMS (Centers for Medicare and Medicaid Services) and reviewed according to the marketing guidelines and other applicable guidance.
- Comply with the “Do not call registry.”
- Provide beneficiaries with information in a professional manner.
- Use a state-licensed, certified, or registered individual to perform marketing, if the state has such a marketing requirement.

Plans may NOT:

- Solicit Medicare beneficiaries door-to-door prior to receiving an invitation.
- Send unsolicited email to a beneficiary.
- Enroll people by phone, unless the person calls them.
- Offer beneficiaries cash payment as an induction to enroll.
- Misrepresent or use high pressure sales tactics to enroll a beneficiary.

Important MA Points to Remember

If you join a MA plan:

- You are still in the Medicare program.
- You still have Medicare rights and protections.
- You still get complete Medicare Part A and Part B coverage.
- You may be able to get your Medicare prescription drug coverage from your MA plan.
- You may be able to get extra benefits offered by the plan, such as coverage for vision, dental, hearing, and/or health and wellness programs.
- You still pay your Part B premium along with your MA plan premium.
- You usually will have to pay some other costs (co-pays and coinsurance).
- You do not need to buy a Medigap policy. If you have a Medigap plan and decide to join an MA plan, you can keep your Medigap policy but there is little reason to do so - your Medigap plan will not pay any deductible, co-pays or insurance while you are in an MA plan.
- In some cases your costs could be higher than in Original Medicare: for example you see a doctor outside of the network.
- Every Fall the plan will send you information about any changes in benefits, costs or service areas.